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UN Special Rapporteur on Violence Against Women

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Submission on: Obstetric Violence in South Africa: Violence against women in reproductive health & childbirth

Introduction

1. This submission provides an overview of the forms of violence girls and women are subjected to when seeking reproductive healthcare, especially during maternity and childbirth. It also summarises key analysis of the causes and drivers of this particular violence against women. Finally, it offers a summary and analysis of the national, regional and international legal frameworks governing the delivery of reproductive healthcare in South Africa and that which aims to protect women's rights, especially their sexual, reproductive health rights.

2. The Commission for Gender Equality (CGE) is an independent statutory body and its mandate is to promote respect for, protect, develop and attain gender equality within all spheres of South Africa.¹ On this basis the CGE has the power to investigate any gender related issues in public or private institutions, either on its own volition or upon the receipt of a complaint.² The Commission is also mandated to make recommendations on legislation and policy affecting the status of gender equality in South Africa and monitor and evaluate the implementation of international and regional conventions acceded to by the South African Government in promotion of inclusivity and equality, which are of the key elements

¹ Section 181 of the Constitution of the Republic of South Africa (1996, as amended), and the Commission for Gender Equality, CGE Act (39 of 1996, as amended).

² Section 11(1)(e) of the CGE Act.



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of the democratic principles provided for under South Africa's Bill of Rights.³ Therefore the CGE undertakes this submission in adherence with its constitutional and legislative mandates.

Overview of this particular form of violence against women

3. The overwhelming majority of South African's –over 80 percent– rely on the public health system.⁴ Furthermore, 88% of girls and women give birth in clinical settings with professional care.⁵ However, only 40% seek antenatal care before 20 weeks gestation, and a minority of women attend the recommended four antenatal visits.⁶ Global research has consistently shown that there is a correlation between unacceptability of health services and willingness to access facility-based care.⁷ Significantly, research and investigations conducted over the last two decades in South Africa have shown that women and girls seeking reproductive healthcare services in the public health system often face physical and psychological violence and mistreatment.⁸ It is important to note that some of these

³ Section 11(i)(h) of the CGE Act; Constitution of the Republic of South Africa (1996, Section 2).

⁴ United States Agency for International Development 'Health Financing Profile: South Africa (2016) Washington DC.

⁵ Republic of South Africa, Department of Health. (2010) 'Campaign on Accelerated Reduction of Maternal and Child Mortality (CARMMA) to reduce maternal mortality in Africa'.

⁶ N. Massyn, and others. 'District health barometer 2012/13' (2013). Health Systems Trust: Durban, 2013. Accessed 3 April 2019 <http://www.hst.org.za/publications/district-health-barometer-201213>.

⁷ For instance see. Sheetal P. Silal and others 'Exploring inequalities in access to and use of maternal health services in South Africa' (2012) BMC Health Services Research 12(120).

⁸ Rachel Jewkes and others, 'Why do nurses abuse patients? Reflections from South African Obstetric Services' (1998) 47(11) Social Science & Medicine; E Farrell and RC Pattison, 'Out of the Mouths of Babes–Innocent reporting of harmful labour ward practices' (2004) 94(11) SAMJ 896; D J Mets, 'Out of the Mouths of Babes – Innocent reporting of harmful labour ward practices' (2005) 95(5) SAMJ 284; Lou-Marie Kruger and Christiaan Schoombee, 'The Other Side of Caring: Abuse in a South African Maternity Ward' (2010) 28(1) Journal of Reproductive and Infant Psychology 84; Peter Moszynski, 'South Africa's rising maternal mortality rate is due to health system failures'. (2011) British Medical Journal 343, d5089; Lauraine M. Vivian, and others 'Medical students' experiences of professional lapses and patient rights abuses in a South African Health Sciences Faculty'. Acad. Med. (2011) 86, 1282–1287; Human Rights Watch, HRW 'Stop Making Excuses: Accountability for Maternal Health-Care in South Africa' (2011). <<http://www.ngopulse.org/resource/stop-making-excuses-accountability-maternal-health-care-south-africa>> accessed 19 December 2018; Sethembiso Mthembu, Zaynab Essack and Anne Strode 'I feel like half a woman all the time': A qualitative report of HIV-positive women's experiences of coerced and forced sterilisation in South Africa' (2011) Her Rights Initiative and HEARD; Zaynab



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scholars have used the term 'obstetric violence,' to identify this particular form of violence against women in South Africa.⁹ This section provides an overview of the forms this particular violence against women takes in South Africa. It uses excerpts from research and investigations into these harms to illustrate the manner and context in which this violence takes place. Finally, it summarises key analysis of the causes and drivers of obstetric violence in South Africa.

4. Forms of physical violence identified in the body of evidence cited in footnote eight include: dragging, pinching, slapping, and applying pressure to the fundus during active labour,¹⁰ and inadequate access to abortion.¹¹ Coercive and unnecessary medical procedures including: caesarean sections,¹² episiotomies,¹³ sterilisations,¹⁴ and the

Essack and Ann Strode, "I Feel Like Half a Woman all the Time": The Impacts of Coerced and Forced Sterilisations on HIV-Positive Women in South Africa' (2012) 26(2) Agenda 24; Ann Strode, Sethembiso Mthembu, and Zaynab Essack, "She Made up a Choice for Me": 22 HIV-Positive Women's Experiences of Involuntary Sterilisation in Two South African Provinces' (2012) 20(s39) Reproductive Health Matters 61; Sheetal P. Silal and others 'Exploring inequalities in access to and use of maternal health services in South Africa' (2012) BMC Health Services Research 12(120); Rachele Chadwick, The right to dignity in childbirth? Public sector birth narratives. (2013) Unpublished NRF report; Rachele Chadwick, 2014. 'Raising Concerns: Quality of care and maternal health services in South Africa' (2014) 8(4) African Journal of Midwifery and Women's Health. pp.130-134; Rachele Chadwick, Diane Cooper, and Jane Harries, 'Narratives of Distress about Birth in South Africa Public Maternal Settings: A Qualitative Study' (2014) 30(7) Midwifery 862; Simone Honikman, Sue Fawcus, and Ingrid Meintjes, 'Abuse in South African Maternity Settings is a Disgrace: Potential Solutions to the Problem' (2015)105(4) SAMJ 284; Rachele Chadwick, 'Ambiguous subjects: Obstetric violence, assemblage and South African birth narratives'. (2017) 27(4) Feminism & Psychology; Jessica Rucell, (2017) 'Obstetric Violence and Colonial Conditioning in South Africa's Reproductive Health System' DPhil thesis, University of Leeds; Amnesty International (2017). *Briefing: Barriers to Safe and Legal Abortion in South Africa*. London: Amnesty International. Rachele Chadwick (2018) Bodies that birth: vitalizing birth politics. London: Routledge; Marie Hastings-Tolsma, Anna G W Nolte, and Annie Temane, 'Birth Stories from South Africa: Voices Unheard' (2018) 31(1) Women and Birth e42.

⁹ Camilla Pickles (2014) 'Approaches to pregnancy under the law: a relational response to the current South African position and recent academic trends. *De Jure*. 47(1), pp. 20-41; Rachele Chadwick, 'Obstetric Violence in South Africa' (2016) 106(5) South African Medical Journal. pp. 5-8; Rucell (n8). This terms was popularised by women's movements in Latin America.

¹⁰ The fundus is the base or upper part of the uterus, which protrudes during pregnancy. Applying pressure to this organ during pregnancy is not part of evidence-based practice. See for instance, Farrell and Pattison (n8); Honikman, et al (n8); Chadwick, Cooper, and Harries (n8); Rucell (n8).

¹¹ Amnesty International (n8).

¹² HRW (n8); Mthembu, Essack and Strode 2011 (n8); Chadwick (n9).

¹³ 'Episiotomy' refers to a surgical incision into the opening of the vagina. See Rucell, (n4) pp. 200-2001. Clinical guidance advises a restriction of this practice. See WHO, 'Recommendations for Prevention and Treatment of



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administration of the three-month injectable contraception, Depo-provera.¹⁵ Physical forms of obstetric violence also concern the use of assisted delivery methods, including instruments and the administration of certain drugs. Particular groups, for instance non-South African's suffer discrimination on the basis of language which has led to neglect and denial of care. Additionally, we further argue two forms of denial of care and lack of access can be interpreted as forms of physical obstetric violence, and exacerbate gender inequality. Firstly, the lack of a wide range of modern *safe* contraceptives (especially the non-hormonal IUCD, and low dose biphasic combined oral contraceptive pill) in South Africa constrains girls, and women's ability to choose contraception. Moreover, the lack of access to abortion services (currently 7% of healthcare facilities provide abortion services) including delay's due to human and material resources often force girls and women to carry to term, and to 2nd trimester.¹⁶

5. The psychological forms identified in the body of evidence cited in footnote eight range from neglect to verbal assaults. In this context, neglect refers to women being turned away from healthcare facilities when they are in active labour and when health professionals responsible for labour wards do not attend to girls and women who have been admitted under their care.¹⁷ Verbal assaults are often noted to take the form of health professionals judging girls and women's sexuality and fertility choices.¹⁸ Thus, the dignity of girls and women who seek reproductive healthcare is undermined through accusations of having

Maternal Peripartum Infections' (2015).

<https://www.who.int/reproductivehealth/publications/maternal_perinatal_health/peripartum-infections-guidelines/en/> accessed 19 December 2018.

¹⁴ South African National AIDS Council, 'The People Living with HIV Stigma Index, South Africa: Summary Report' (2015) <<http://www.stigmindex.org/sites/default/files/reports/Summary-Booklet-on-Stigma-Index-Survey%20South%20Africa.pdf>> accessed 19 December 2018; Strode, Mthembu, and Essack (n8) pp. 61.

¹⁵ Rucell (n8); Jessica Rucell and Catriona Towriss. Presentation of preliminary findings: Quantifying the coercive delivery of post-partum contraception' 8-12 July 2018 Rhodes University, Abortion and Reproductive Justice: The Unfinished Revolution conference.

¹⁶ Amnesty International (n8).

¹⁷ See HRW (n8).

¹⁸ See Rucell (n8) 197-198; Chadwick, Cooper and Harries (n8); Chadwick, 2018 (n8).



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poor morals, and blaming for poor birth outcomes.¹⁹ Moreover, research has consistently found such verbal assaults to be normalised and routinely practiced.²⁰

6. Furthermore, building on the Human Rights Council which has, since 2009 acknowledged the unequal and preventable rate of maternal mortality (MMR) globally to be a form of violence against women, we raise a link between obstetric violence and South Africa's high-rate of MMR.²¹ The most recent annual report from the South African National Committee on Confidential Enquiries into Maternal Deaths, NCCEMD found that MMR is approximately 134 per 100,000 live births, and importantly that 60% of facility-based maternal deaths were 'potentially preventable'.²² Making a similar connection the latest Saving Mothers report on maternal deaths found the majority of deaths to result from 'mostly poor quality of care' and divided these factors into: administrative, patient, and care factors.²³ Importantly, some scholars, including clinicians have suggested there is a link between preventable MMR and obstetric violence, especially in the form of neglect.²⁴ Data on maternal mortality remains inadequate, and for instance does not distinguish based on violent negligence, or other forms of malpractice.

¹⁹ Ibid.

²⁰ Jekwes et al (n8); Kruger and Schoombee (n8); HRW (n8); Rucell (n8); Chadwick, 2018 (n8).

²¹ OHCHR Office of the High Commissioner on Human Rights (2010) *Report of the Office of the United Nations High Commissioner for Human Rights on preventable maternal mortality and morbidity and human rights to the Human Rights Council. A/HRC/14/39*. Geneva: UN.

²² NCCEMD, National Committee for the Confidential Enquiries into Maternal Deaths, (2017) *Saving Mothers 2017: Annual Report*. Pretoria: Department of Health South Africa.

²³ NCCEMD, National Committee for the Confidential Enquiries into Maternal Deaths (2018) *Saving Mothers 2014-2016: Seventh triennial report on Confidential Enquiries into Maternal Deaths in South Africa (short report)*. Pretoria: Department of Health South Africa. pp.174.

²⁴ Farrell and Pattison (n8); Mickey Chopra and others (2009) 'Saving the lives of South Africa's mothers, babies, and children: can the health system deliver?', *Lancet* 374, 835-845.



Illustrating the forms of obstetric violence in South Africa

7. The earliest study on this topic was conducted by Rachel Jewkes, Naeemah Abrahams and Zodumo Mvo (1998) and revealed many of the problems noted above, including the pervasive humiliation and neglect of women during childbirth, as well as physical violence and verbal abuses in maternity services.²⁵ Jewkes and her colleagues findings were based on 103 interviews and four focus groups conducted in 1996/1997 with patients and staff in obstetric services in the Western Cape province of South Africa. The study identified violence against women in this context to be structural. For instance, the study found that violence was institutionally normalised because of a lack of accountability and action by managers, dysfunctional or absent mechanisms of complaint, an underlying ideology of patient inferiority and professional sanctioning of coercive behaviors. Furthermore, violence was found to be ritualised in some obstetric settings with nurses using violence as a means of controlling birthing women and creating social distance from poor and marginalised patients. For instance the authors reported:

A senior nurse asserted that she did not think that there was a midwife in the service who had never slapped a patient in labour. She continued to assert that it was a misrepresentation to describe this as “beating” (the patients' word) as, she explained, one would “cup one's hand and slap the thigh” and she proceeded to demonstrate this with gestures.²⁶

Two women were slapped on the face as punishment. One woman described how she had gone to the toilet and could not get up on the bed when she got back, was hit by a midwife who found her squatting by a bed on the floor. The midwife refused to help her onto the bed and she had to wait until another came by. Another woman was slapped on the face after delivering on the floor. She had been told to fetch a sheet (“I'll slap you if you deliver on that sheet without a plastic cover”) from a cupboard when the baby was apparently already emerging. After the delivery she was told “clean up your mess!” and to pick up the baby as the midwife said should would not “mess (her) hands” with him.²⁷

²⁵ Jewkes et al (n8).

²⁶ Jewkes et al (n8) pp. 1790.

²⁷ Jewkes et al (n8) pp. 1786.



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8. A decade later, Lou-Maree Kruger and Christiaan Schoombee (2010) conducted a qualitative longitudinal study, also in the Western Cape province and found similar forms of violence against women.²⁸ For example, they found patient abuse and neglect to be prominent themes of women's accounts of childbirth. It was also found that, although accepted by law only 15 percent of women had a birth companion with them during childbirth.²⁹ Earlier research, conducted in Gauteng province by clinicians found non-evidence based obstetric practices to be routine.³⁰ For instance:

Lea: Because they work very poorly with the girls. Very poorly. Especially if you are a girl and you are not married and you arrive there. Then they are rough with you. And especially the black girls. They are *sommer* hit, if they do not want to open their buttocks or if they don't want to push, then they're hit between the buttocks. This they do. Now who wants to be hit if they already are in pain? You can't do it like that.

Suzanne: The sister takes her fingers and pushes them up in you, then she feels, she is practically digging, sorry that I tell it to you like this. Then it is so painful ... But they weren't too bad. They just, they just are, it almost is ... it is sore and you have to stand your man. I mean if I keep my legs closed then they will dig, then I keep closed and then it is 'Open your legs'. Now, not nasty, but they also are not the friendliest people. 'Open your legs. You knew it would be painful and it must finish now'. And I have to open my legs so that the process can begin.

Makeila: But it was just, they did, one of them really pushed me in very painful ways on the inside, because I did, the afterpains were very sore.³¹

9. In the research conducted in the Eastern Cape province by Human Rights Watch (2011) in which 16 health facilities were observed, and 157 women, and 30 nurses were interviewed it was found that maternal health services were characterised by substandard care.³² In some cases, this reflected the health service placing mothers and infants in life-threatening

²⁸ Kruger and Schoombee (n8).

²⁹ Department of Health, *Guidelines for Maternity Care in South Africa: A manual for clinics, community health centers and district hospitals* (2015) 47.; World Health Organization, WHO. 'Recommendations for augmentation of Labour'. (2014) Geneva: World Health Organization.
<http://www.who.int/reproductivehealth/publications/maternalperinatalhealth/augmentation-labour/en>

³⁰ Farrell and Pattinson (n8); Vivian et al. (n8).

³¹ Ibid. pp. 95.



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situations. For example, where women were repeatedly neglected or denied care during their labour. Additionally, a failure to provide adequate pain relief, and informed consent were found. Furthermore the research found, evidence of widespread physical and verbal abuse (with more than 50% of women reporting such incidents). Refugees were found to especially face discrimination in the form of neglect and denial of care, including denial of pain and other medication after caesarean section. Additionally, in four cases refugees reported being coerced into caesarean sections.

10. Building on this research are testimonies obtained by the CGE. Throughout South Africa in 2017 the CGE in partnership with several stakeholders convened dialogues in preparation for a national strategic plan on UN Security Council Resolution 1325 (2000), which asserts the importance of gender equality to peace and development. Over the last decade foreign African's have been targets of discrimination and violence in South Africa. Thus, the dialogues prioritised the participation of refugees and asylum-seeking women. Often in the dialogues these participants raised issues relating to the healthcare system. For instance:

Efua: Shared that she was due with a child when she fled her country of origin. During the journey she had a complicated birth, and the child died shortly after being born. Efua continued her journey to South Africa for refuge and was unable to birth the placenta and was in horrible pain upon arrival and needed urgent medical care. Once in South Africa Efua explained she struggled to access urgent medical care. As the hospital she presented to insisted that as a foreign national without documentation, she did not qualify for free medical assistance and had to pay. This caused her to have to find someone to pay for her care, which delayed her care further.³³

11. The excerpt from Efua's testimony shows that hospital practices is at times outside of Constitutional and legislative provisions. In this case the barriers Efua experienced in an obstetric emergency was in contradiction with Section 27 of the Constitution which

³² HRW (n8). At the time of interview the women had received care or accompanied someone who had received care in a public hospital in the past five years.

³³ All names of participants, and complainants used in this submission have been anonymised.



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provides the right to have access to health care services to everyone, including reproductive health care services, and that moreover stipulates the right not to be denied emergency medical treatment regardless of citizenship. The same provision is reflected in Section 4(3) of the National Health Act which further provides for certain free health care services for people who do not have private medical aid (insurance). It is important to note that some existing provincial legislation contradicts these constitutional provisions, which in practice complicates access to healthcare. For instance, the Gauteng Hospitals Ordinance Amendment Act 4 of 1999 gives the CEO of a hospital powers to demand identification documents before admission to a hospital except where deferring treatment may have “dangerous or detrimental consequences” to the person seeking treatment.

12. Research carried out by Rachele Chadwick, based on interviews with 33 women about their recent childbirth experiences in public hospitals in the Western Cape found that more than half of the adolescents and women interviewed (n=18) experienced distressing births.³⁴ The study found adolescent’s and women’s experiences of facility-based maternal healthcare to be characterised by negative interpersonal exchanges with healthcare professionals, lack of information, pervasive neglect and the denial of a labour companion during childbirth. The below narratives from this research illustrate the routine and normalised practice of psychological violence in maternity services. For example:

Jasmine: Yes, they’re RUDE, they will just tell you, they will say, ‘No you did that *lekker*’ – that kind of stuff, they will, because I remember from [first baby] I was supposed to walk up and down, up and down, up and down and they were sitting in a room, they were sitting in a room and when you say the pain is coming or you go get on the bed, they will **shout** at you, ugly remarks.

³⁴ Chadwick, Cooper & Harries (n8); Chadwick 2017; 2018 (n8). Women were six weeks postpartum at time of interview.



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Fadwah: And um like I was pushing I was moving on the bed because of the plastic that was on the bed and **I didn't notice** I was moving, like she told me I must lay straight and I didn't know that I was like moving and then **she shouts** and then she say 'Lay straight, why are you laying that way? (cross voice) and I just left her because I didn't take note about them shouting and being rude because of the pains I just did my thing.

13. Other women reported being threatened with violence, for instance:

Wendy: Nobody came, the pains got stronger and stronger and um, then I went to one sister and *asked* her like, 'Won't she check me to see how *far* I am, how many centimetres I am' and um then she said 'No um, does she, do I want one, one of them to get **angry** with me?' they are going to get **angry** and scold me if I now ask how many centimetres and that they must check on me, and then, um, then I left it and then went back to the room because I didn't want big trouble, then I left it and nobody checked me.

14. In the same study, other participants spoke of being distressed by the pervasive neglect that they experienced in maternity services during childbirth. Being left alone, denied care and neglected were common threads of adolescent's and women's birth experiences. Several participants reported being left unattended and unmonitored during childbirth. This neglect often persisted until women screamed for help and delivery was either imminent or had already occurred. As a result, some participants reported coming close to giving birth unattended, even while in healthcare services. For example:

Rosetta: They [healthcare providers] didn't support me, I basically gave birth alone which *um* there should have been someone with me to help me and – you know? But there was nobody.

Madiha: They [healthcare providers], *they didn't take note of us*, they did their own thing, walked away, went and sat *there on a couch*, *far* away from us, sat on a couch and **then**, then I felt the baby's head is going to come out, then I wanted to walk there but then I saw that I can't, [*can't walk*], then I screamed 'Sister, the baby is coming now!' then she said 'No, go and lie on the bed man, the baby isn't coming now!' and then, then I said to the other girl 'Go and tell the sister the baby is coming



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now' because the head had already come out, then she went to tell and then they came running, and then they got their things together.

Coercive and forced medical procedures

15. Sterilisation is a medical procedure performed on women either through tubal ligation, or hysterectomy that permanently blocks one's fertility. Forced sterilisation occurs when an individual is sterilised without their knowledge or is coerced into giving consent, for instance when financial or other incentives, misinformation, or intimidation tactics are used to compel one into the procedure, or consent is obtained based on false or incomplete information.³⁵ Examples of coerced and forced sterilisation have been documented in southern Africa.³⁶ Yet until recently there has been very limited data on involuntary sterilisation in South Africa. Recently, research and investigations have been undertaken to address this gap in information. Research has particularly focused on HIV positive women, and showed a pattern of coercive and forced sterilisation. The following section provides an overview of extant evidence.

16. Firstly, research into coercive and forced sterilisation of HIV positive women was undertaken between 2010 and 2011 by Ann Strode, Sethembiso Mthembu, and Zaynab Essack (2012).³⁷ The study screened 32 HIV positive women in Gauteng and KwaZulu-Natal provinces using a questionnaire. This identified 25 (68%) of those screened as having undergone an involuntary sterilisation procedure. The authors concluded:

³⁵ Eliminating Forced, Coercive and Otherwise Involuntary Sterilisation: An Interagency Statement, OHCHR, UN Women, UNAIDS, UNDP, UNFPA, UNICEF and WHO, World Health Organization (2014) 3.

³⁶ ARASA. (2008). Sexual and Reproductive Health Rights Advocacy Workshop Report. 21–22 October 2008, Johannesburg, South Africa; Gatsi, J., Kehler, J., & Crone, J. (2010). Make it everybody's business: Lessons Learned from addressing the coerced sterilisation of women living with HIV in Namibia: A best practice model. Accessed 17 May 2019

<http://www.athenanetwork.org/assets/files/Make%20it%20everyone's%20business...%20--%20Report.pdf>; Nair, P. (2010). Litigating against the forced sterilization of HIV-positive women: Recent developments in Chile and Namibia. *Harvard Human Rights Journal*, 23, 223–231.

³⁷ Strode, Mthembu & Essack (n8).



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Most women in our study reported that they were coerced into having a sterilisation. These women's accounts indicate that their "consent" to sterilisation did not always meet the criteria of fully informed, voluntary and free from pressure and coercion. From their reports, it appears that the informational component of the informed consent process was not always satisfied, as the sterilisation procedure and its consequences were rarely explained. Most women described signing a consent form under very stressful circumstances, such as while they were in active labour or while being wheeled to the theatre. Others reported being coerced into accepting a sterilisation in order to receive another healthcare service like an abortion or caesarean section. Women reported that the provision of appropriate and accurate information about the sterilisation was inadequate and that they felt unable to make an independent and informed decision because they were often in distress.

A few of the women reported that they had experienced a forced sterilisation, that is, they were unaware of the sterilisations until sometime after the procedure. Women described being discriminated against by healthcare providers... This discrimination manifests in different ways. In their view, in addition to being forced or coerced to undergo sterilisation procedures, the women in this study reported being routinely abused, humiliated and bullied by healthcare workers.³⁸

17. Secondly, the SA National Aids Council's 2015 stigma index revealed that, out of 6,719 HIV positive women interviewed, an estimated 500 said they had been forcibly sterilised.³⁹ According to this report, 7% of respondents responded that they 'were forcefully sterilized while 37% of the respondents said that access to ARV treatment was conditional on use of contraceptives.⁴⁰

18. In March 2015, the Women's Legal Centre lodged a complaint with the CGE on behalf of 48 women living with HIV represented by Her Rights Initiative (HRI), and the International Community of Women Living with HIV (ICW). The 48 women complainants had been coerced or forcefully sterilised between 1986 and 2014. These experiences occurred in the

³⁸ Mthembu, Essack & Strode (n8) pp.2-3.

³⁹ South African National AIDS Council (n15) pp.1-26.

⁴⁰ Ibid.



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provinces of KwaZulu-Natal, and Gauteng in 15 public hospitals while seeking maternal healthcare services. In response to the complaint the CGE conducted a preliminary investigation. Further investigation, and interdepartmental consultations are ongoing. The below summaries are excerpts from women who have participated in this investigation.

Ms. A: reports that in 2011 she became pregnant and began attending antenatal care at Nkandla hospital, KwaZulu-Natal province. During one of her final antenatal visits, when she was almost due, she was informed by the staff that she would be giving birth via caesarean section and was given an appointment date of 18th September 2011. However, Ms A. could not make it on that day because of transport problems and went to Nkandla hospital on 19 September 2011 instead. She averred that she was alone in hospital without the support of her family. Ms. A stated that she tried to contact her family, but her handbag containing her mobile phone was taken away from her before she could inform her family that she had been admitted. Ms. A further reports that she was coerced into completing sterilisation forms against her will. Ms. A said the hospital staff threatened her that they would not assist her to give birth until the forms were duly completed. Ms. A ultimately signed the forms under duress.

Three months later, Ms. A disclosed to her fiancé that she had been sterilized by Nkandla hospital. Her fiancé, infuriated called a family meeting that included extended family members. Even though some expressed sympathy, others ridiculed Ms. A and expressed their disappointment in Ms. A. The complainant avers their marriage could not proceed because the fiancé was no longer interested in pursuing the relationship for her lack of fertility.

Ms. B: Reported to be 24 years old, and seven months pregnant when she went to Addington hospital, KwaZulu-Natal on 14 October 2001 for antenatal care. Upon her arrival, she was allegedly diagnosed with extreme high blood pressure, and told by the attending nurse that with hospital admission and treatment it could be lowered or stabilised. Reportedly this did not occur and Ms. B was booked for a caesarean-section the following day, 15 October 2001. Upon booking Ms. B reported that she was given forms by an attending nurse, who instructed her that she needed to sign the forms for the caesarean before she could be taken into theatre for the procedure. Ms. B reported that she signed the forms presented to her and was under the impression that they only concerned the caesarean-section. Ms. B's son was delivered via caesarean-section on 15 October and she was allegedly sterilised without her knowledge during the same procedure. The following day, while still admitted in Addington hospital the wound from Ms. B's caesarean became infected, and two weeks later it still had not healed. At this point, Ms. B was transferred to



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King Edwards a tertiary hospital, for more advanced care. Ms. B remained in King Edwards hospital for two and half months, and despite repeated requests to understand why the wound did not heal was never told what exactly had happened to her. A few years later after failing to conceive Ms. B went to a private doctor. The doctor's examination concluded that Ms. B had been sterilised and as a result, was made infertile. Ms. B further reported that her infertility has caused her partner to leave her.

Ms. D: was eight months pregnant, felt sick and weak and reported to have gone to Magwaza district hospital, KwaZulu-Natal on 22nd September 2002 where a doctor examined her and diagnosed her with tuberculosis. Ms. D reports she was then told by the doctor that she would have to give birth via caesarean-section, and was booked in for the procedure on 26th September, and admitted on 25th September 2002. Upon admission to the hospital a doctor attended to Ms. B and informed her that she would be sterilised because if she were to have children again they would die. Ms. B. reports that he also allegedly informed her about the forms she needed to sign. Ms. B. reported that prior to the caesarean-section she received an injection, which made her feel dizzy, and she could not remember whether or not she signed the sterilisation forms. Ms. B delivered via caesarean-section and was allegedly sterilised. A few years later, she tried to conceive again but could not. She reported to be suffering from depression since then, and said, to her, her body has never been the same.

Ms. C, who in 2004 was pregnant, 20 years old, and on the evening of 18th September was rushed by ambulance to Steve Biko hospital, Gauteng province after experiencing labour pains. Ms. C. reports that upon examination, blood was found in her urine and a doctor advised her that due to this she would have to deliver through caesarean-section. Ms. C. still in labour, reports the doctor further explained that it would be best for her to sterilise to prevent her from bleeding to death should she become pregnant again. Ms. C, at that stage indicated to the doctor that she did not understand what it meant to be sterilised. Ms. C reports that whilst signing the forms given by the doctor, that she was in extreme labour pain, and that she did not understand what it was that she was signing. The delivery through caesarean-section was carried out, and her son was born, and she was sterilised thereafter. Ms. C. reports that one year later her infant son died from tuberculosis. Her attempts to conceive after the death of her infant failed. At this time Ms. C was twenty-one years old, visited a private gynecologist, who examined her and determined she had in fact been sterilised. The gynecologist informed Ms. C that her fallopian tubes had been damaged, and that sterilisation is permanent. Ms. C reports that her heart sank, upon learning this and that she has experienced bouts of depression because of her infertility ever since.



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19. Collectively this evidence summarises the violent practices carried out through maternal healthcare which constrain individuals' capability to have children safely and with dignity in South Africa. Moreover, this evidence has indicted that obstetric violence is maintained and driven structurally through gender and other forms of discrimination, resource constraints, a lack of accountability, and through problems with the governance and management of obstetric and maternity staff.⁴¹ An analysis of the causes and drivers of this particular form of violence against women is further detailed in the analysis section below.

Relevant National Legal and Policy Frameworks

20. For over twenty years the Republic of South Africa's Constitution, and Bill of Rights has provided girls and women rights, including sexual reproductive health rights (SRHR). This section gives an overview of the national legal and governing frameworks guiding the delivery of reproductive health services in South Africa.

21. South Africa's governing framework provides broad protections for women's rights including SRHR and social-economic rights. For instance:

- *The Constitution of the Republic of South Africa (Act 108 of 1996).*
- Chapter 2 provides:
 - (Section 9) The right to equality: Stipulates everyone is equal before the law and has the right to equal protection and benefit of the law. Equality includes the full and equal enjoyment of all rights and freedoms.
 - (Section 10) The right to dignity.⁴² The right to dignity is an acknowledgement of the intrinsic worth of human beings, independent of their station in life, without dignity, human life is substantially diminished. For instance, it is only when a person is treated with dignity that they are affirmed as worthy and important in society.
 - (Section 12) The right to freedom and security of the person. This right includes to be free from all forms of violence from either public or private sources; and further that everyone has the right to bodily and psychological integrity, which includes the right to security in and control over their body.

⁴¹ For further analysis see Jewkes et al (n8); HRW (n8); and Rucell (n8).

⁴² *S v Makwanyane and Another* (CCT3/94) [1995] ZACC 3; 1995 (6) BCLR 665; 1995 (3) SA 391; [1996] 2 CHRLD 164; 1995 (2) SACR 1 (6 June 1995).



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- (Section 27) The right to access health care services (including reproductive health care) and emergency medical treatment.
- (Section 36) Limitation of rights. This right pertains to the limitation of enjoyment of rights enshrined in the Constitution. It provides that 'the rights in the Bill of Rights may be limited only in terms of law of general application and only to the extent that the limitation is reasonable and justifiable in an open and democratic society based on human dignity, equality and freedom, taking into account all relevant factors, including— (a) the nature of the right; (b) the importance of the purpose of the limitation; (c) the nature and extent of the limitation; (d) the relation between the limitation and its purpose; and (e) less restrictive means to achieve the purpose.'

22. Additionally, several laws and regulations are particularly relevant to obstetric violence:

- *The Choice of Termination of Pregnancy Act (92 of 1996).*
 - This legislation has been a major advancement for women's human rights. It gives women and girls the right to have an abortion on request up until the 12th week of pregnancy and with certain conditions before the 20th week.
- *The Sterilisation Act (44 of 1998.)*
 - This legislation provides for the right to sterilisation. (Section 5 - 6) of the Act recognises that both men and women have equal rights to be informed of, and have access to safe, effective, affordable and acceptable methods of fertility regulations. (s2) Requires that a patient provide his or her informed consent for sterilisations. "For the purposes of this Act, "consent" means consent given freely and voluntarily without any inducement and may only be given if the person giving it has— (a) been given a clear explanation and adequate description of the— (i) proposed plan of the procedure; and (ii) the consequences, risks and the reversible or irreversible nature of the sterilisation procedure; (b) been given advice that the consent may be withdrawn any time before the procedure; and (c) signed the prescribed consent form."
- *The National Health Act (61 of 2003)*
 - This legislation puts in place a framework for the structure of a uniform health system taking into account the obligations imposed by the Constitution and other National, Provincial and Local Government Laws with regards to Health Services, and stipulates the regulation for community oversight of the health system within these parameters.
 - (Section 4) Mandates the provision of free healthcare services to all pregnant and breast-feeding women.
 - The Act reaffirms the constitutional rights of users to access health services as well as just administrative action.
 - (Section 18) enables any user of health services to lodge a complaint about the manner in which they were treated. The Act further requires Members of the Executive Councils of Provinces to establish procedures for complaints.



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- *Guidelines for Maternal Care in South Africa (2015)*⁴³
- The guidelines provide, among other things, a practical approach for primary healthcare to manage pregnancy, labour and childbirth with the ultimate aim of reducing MMR. The guidelines are for health professionals providing obstetric, surgical and anaesthetic services for pregnant women. The guidelines are aimed at supporting the localised development of protocols for identifying, diagnosing and managing common and serious pregnancy and delivery problems. The guidelines respond to recommendations by NCCEMD, with the overall aim to improve clinical management and referral to reduce pregnancy-related deaths and ill health.⁴⁴
- *Department of Health Complaints Procedure (2017)*⁴⁵
- The purpose of the procedure is to provide direction to the health sector in managing complaints, compliments and suggestions by ensuring that standards and measures as set out by the National Department of Health, the Department of Planning, Monitoring and Evaluation in the Presidency and the Department of Public Service and Administration are adhered to.
- The Guideline also gives guidance to ensure that the right of patients and/or their families/support persons to complain is upheld. This is achieved by setting out processes to ensure that patients/families and support persons are informed on how to lodge a complaint or record a compliment or suggestion and on what to subsequently expect.⁴⁶

23. Additionally, several authorities with governing oversight both binding and unbinding are relevant for the particular problem of obstetric violence:

- *Health Ombudsman (established 2016)*
 - Has been created as an independent office in the terms of the National Health Amendment Act 12 of 2013.
 - The office is accountable to the Minister of Health, and is assisted by the Office of Health Standards and Compliance. The office is mandated to investigate and make recommendations on complaints and ensure redress for malpractice in the health systems.

⁴³ Department of Health, South Africa. 'Guidelines for Maternity Care in South Africa. A Manual for Clinics, Community Health Centres and District Hospitals'. (2015) 4th ed. Pretoria: NDoH, 172. <http://www.health.gov.za/index.php/2014-03-17-09-09-38/policies-and-guidelines/category/230-2015p#> (accessed 8 June 2017).

⁴⁴ HL Malherbe amongst others, 'Review of the 2015 Guidelines for Maternity Care with relevance to congenital disorders'. (2016) South African Medical Journal. 106(7).

⁴⁵ Department of Health, South Africa. 'National Guideline to Manage Complaints, Compliments and Suggestions in the Health Sector of South Africa' (2017) Pretoria: NDoH.

⁴⁶ Ibid.



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- *Office of Health Standards and Compliance (established 2013)*
 - Has been created as an independent body by (Section 78) of the National Health Amendment Act 12 of 2013. The Office's objective is to protect and promote the health and safety of users of health services. With this view the Office is mandated to enforce compliance with norms and standards proscribed by the Minister of Health, and monitor, inspect, certify and investigate health services in accordance with legislation setting the quality and standard of healthcare. The office is additionally able to make recommendations for improvement.
- *South African Nursing Council, (SANC) Nursing Act 33 of 2005 & the Health Professions Council of South Africa (HSPCA) Health Professions Act 56 of 1974*
 - Both of these professional associations are independent statutory bodies established by law and reinforce South Africa's constitutional commitments by binding healthcare workers to its ethical principles and code of conduct. Further, they guide and regulate their associated health professionals pertaining to registration, education and training and conduct, ethical behaviour and ensuring compliance with healthcare standards.
 - Additionally, both associations are mandated to investigate complaints, and are empowered to provide binding discipline, including punitively to registered health professionals.

Conclusion

24. By foregrounding the existing evidence, this submission has established that violence against women and mistreatment within reproductive health services is a persistent problem in South Africa. This particular violence against women takes diverse forms of physical and psychological violence, and arguably has impacts on women and neonatal health.⁴⁷ Women's sexual and reproductive health and well-being is dependent on social determinants of health, including inequality, socio-political rights and access to quality health resources. Collectively the body of evidence provided here indicates obstetric violence is driven structurally rather than for example by individual actions through one group of health professionals. Moreover, health systems reflect and reinforce societies' dominant social and cultural values.⁴⁸ Thus, the causes of violence against women in maternity are entrenched gender and other forms of discrimination, gender inequality, inequality of health services and the socio-economic constraints resulting in public health

⁴⁷ See note 8 and in particular to poor health outcomes Chopra et al (n8); Mozsynski (n8).

⁴⁸ S. van der Geest, & K. Finkler, 'Hospital ethnography: Introduction'. (2004) *Social Science and Medicine*. 59(10), pp.1995–2001.



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services lack of human, and other resource capacity. Normalising this gross problem, is the poor quality of accountability and management.⁴⁹

25. Nevertheless, this submission has established that South Africa has a comprehensive legal and policy framework that centres the right to health as enshrined in the Constitution and Bill of Rights. This framework guides the delivery of health services, and the state response to violence against women, including that arising through reproductive health services. South Africa's health system continues to be bifurcated between a private and public system. However, these barriers of inequality are addressed by certain legislation, for instance, Section 4 of the National Health Act (61 of 2003) ensures all pregnant and breastfeeding women and children under the age of six have access to free public healthcare. This provision of access to public healthcare services is significant for the prevention of certain forms of obstetric violence, and must not be overlooked.⁵⁰ Moreover, health systems reflect and reinforce societies' dominant social and cultural values.⁵¹ These values are not stagnant, and as they change they re-shape health system and provider/patient relations.⁵² Thus it is important to note that the DoH Complaints Procedure was established in 2017 and the Health Ombudsman in 2016. This changing environment of health governance reflects the trajectory of change in South Africa as a young democracy, with only recently having established patient, and women's rights. Given South Africa's recent enhancement of robust and independent health governance, and the persistence of this particular form of violence against girls and women it is recommended that the Special Rapporteur invites the CGE to provide oral testimony on this problem, and also visits South Africa to investigate this critical issue of women's rights.

⁴⁹ Jewkes et al (n8); Mozsynski (n8); Rucell (n8).

⁵⁰ For instance see, CRR, FIKA. 2007. *Failure to Deliver: Violations of Women's Human Rights in Kenyan Health Facilities*. New York: Centre for Reproductive Rights, Federation of Women Lawyers—Kenya.

⁵¹ van der Geest and Finkler (n48)

⁵² Lucy Gilson, 'Trust and the development of health care as a social institution'. (2003) *Social Science & Medicine*. 56(7), pp.1461